Health Information

Child Name: _____

1. Primary Physician:
   *Name: _____

   Phone: (____) ____-_____ Fax: (____) ____-_____ (###) ###-####

   Address: _____

   City: _____ State: ___ Zip _____

2. Other Physicians: _____

3. Medications: _____

4. Emergency Factors: _____

_____

5. Bacterial Meningitis: __Yes (If, yes, flag for audiological screen)

6. Family History of Early Onset Hearing Loss: __ Yes (If, yes, flag for audiological screen)

7. Severe Head Trauma: __ Yes (If, yes, flag for audiological screen)

8. Prolonged Otitis Media and/or Middle
   Ear Fluid Greater than 2 Months: __Yes (If, yes, flag for audiological screen)

9. Syndrome Associated with Hearing Loss (check all that applies):

__ Brachmann-De-Lange Syndrome	__ Kearnes-Sayne Syndrome	__Pfeiffer Syndrome
__ Cleidocranial Dysplasia	__ Kneist Dysplasia	__Seathre-Chotsen
__ Crouzon Syndrome	__ LADD Syndrome	__Scheie Syndrome
__ Goldenhar Syndrome	__ Neurofibromatosis 2	__Stickler Syndrome
__ Hajdu Cheyney Syndrome	__ Norrie Disease	__Usher Syndrome
__ Jackson Weiss Syndrome	__ Perrault Syndrome	__Waardenbury Syndrome

Note: If additional space is needed please attach a separate sheet for reference.

Birth Information

1. Birth Weight: _____ (Gram) (if less than 1500 grams, flag for audiological screen)

2. Birth Length: _____ (inch)

3. Gestational Age: _____ (Weeks) (if less than 34 weeks, flag for audiological screen)

4. Multi-Birth: __ Yes (check only if yes)

5. Special Considerations (flag for audiological screen for Bilirubin, Birth Defects, and Congenital Infection):

__ Bilirubin=20 mg per di	__ Brain Bleeds	__ Breathing Difficulties
__ Birth Defects involving Craniofacial structure (i.e. ear anomaly)	__ Jaundice	__ Forceps Vacuum Extraction
__ Cord Around neck	__ Congenital Infection (i.e. cytomegalovirus, Herpes, toxoplasmosis)	__ Meconium Staining
__ Feeding Difficulties	__ Surgeries	__ Other

6. Birth Comments: _____

_____

Pregnancy Information

1. Which Pregnancy is this? __1 __ 2 __ 3 __ 4 __ 5 __ 6 __ other

2. Month of Routine Prenatal Care Received if yes: __1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9

3. Pregnancy Complications/Illness:

__ Bleeding	__ Rh Incompatibility	__ Increased Blood Pressure	__ Trauma
__ Chronic Disease	__ Toemia/Preeclampsia	__ Gestational Diabetes	__ Preterm Labor
__ Alcohol	__ Illegal Drug Use	__ Tobacco Use	__ Infections

4. Medications: _____

_____

5. Pregnancy Comments: _____

_____